AMIR SAFFARIAN, M.D. INC

FEMALE PATIENT QUESTIONNAIRE:

Name _____ Date_____

Age _____ Family Physician _____

Reason for Visit -

_____

_____

_____

Urinary Symptoms	**Yes**	**No**
Burning on Urination	____	____
Frequent urination	____	____
Urgent need to urinate	____	____
Do you awaken at night to urinate	____	____
If yes, how many times	____	
Have you ever seen an urologist before?	____	____
If yes, why and what was done?		

_____

_____

Urinary Tract Infections	**Yes**	**No**
Have you ever had a prior urinary tract infection	____	____
If yes		
How many?	_____	
Last infection ?	_____	
Age infections started ?	_____	
Have you ever had a fever with infection?	____	____
Have you ever had pain in the back with infection?	____	____
Have you ever had X-rays of the kidney?	____	____
Were you ever hospitalized to treat an infection?	____	____
Have you ever had a sexually transmitted disease?	____	____

I have reviewed the contents of this history in its entirety. _____MD Date _____

Incontinence	**Yes**	**No**
Do you leak urine with:		
Coughing, Sneezing, walking?	____	____
Urgency, can't get to bathroom?	____	____
At night?	____	____
During sexual intercourse?	____	____
Do you use pads for protection?	____	____
If yes, how many? ____		
Do you have to strain to empty your bladder?	____	____
Have you ever had surgery for this reason?	____	____
If yes, please list date _____		
Procedure/Surgeon _____		

Kidney Stones	**Yes**	**No**
Do you have any pain in the back or abdomen?	____	____
Have you ever had a kidney stone before?	____	____
If yes, when? _____		
How many? _____		
Passed on own? _____		
Surgically removed? _____		
What was the stone made of? _____		
Did you have a work-up to determine the cause?	____	____
Any prior dietary changes or medications?	____	____
If yes, what?_____		

_____

Hematuria	**Yes**	**No**
Have you ever seen blood in the your urine?	____	____
If yes, when? _____		
How many times? _____		
Did you have any pain or burning at the time?	____	____
Has a doctor ever found blood with a microscope?	____	____
Have you ever had prior work up for this problem?	____	____
If yes, when? _____		
What was done? _____		
What was found? _____		
Which urologist? _____		

Reproductive History	**Yes**	**No**
Have you ever been pregnant?	____	____
If yes, how many times? _____		
How many children do you have? _____		
How many Cesarean Sections? _____		
Have you had a hysterectomy?	____	____
If yes, why and when? _____		
_____		
Do you have pain with sexual intercourse?	____	____

Medical History

Illness Date discovered Treatment

1._____
2._____
3._____
4._____

Surgical History

Surgery Date Surgeon

1._____
2._____
3._____

Medications

Name Dosage How often (ie once or twice a day)

Please make sure to include **DOSAGE** and ANY blood thinners (ie. Aspirin, plavix, coumadin, ibuprophen or herbal medications

1._____
2._____
3._____
4;_____

Allergies NO KNOWN DRUG ALLERGIES

Name of medication Reaction

1._____
2._____
3._____
4._____

Family Member Age Disease

1._____Father_____
2._____Mother_____
3._____

Social History Yes No

Do you or have you ever smoked? ____ ____
If yes, how much? _____packs/day
How long? _____
Have you quit? _____ If yes, when _____
Do you drink alcohol? ____ ____
If yes, how much? _____
How long? _____
Are you employed? ____ ____
If yes, what type of work? _____
Marital status _____ single, _____ married, _____ divorced

Review of Systems	Yes	No	Describe
Have you ever had serious problems with: (please circle)			
Constitutional (fevers, chills, headache)	**Y**	**N**	
Integumentary (skin rash, itchiness, Boils)	**Y**	**N**	
Eyes (blurred vision, Double vision, pain)	**Y**	**N**	
Ears, nose and throat (sore throat, ear infection Sinus problems)	**Y**	**N**	
Neurologic (tremors, dizzy spells, Numbness/tingling)	**Y**	**N**	
Endocrine (tiredness, excessive Thirst, too hot/cold)	**Y**	**N**	
Heart (chest pain, heart attack, , high blood pressure.)	**Y**	**N**	
Lungs (shortness of breath, TB, asthma cough, wheezing.)	**Y**	**N**	
Gastrointestinal (ulcers,hepatitis, abdominal Pain, nausea/vomiting bleeding,ect.)	**Y**	**N**	
Hematologic (bleeding, blood clots lymphoma, anemia, ect.)	**Y**	**N**	
Psychiatric (depression, mental illness)	**Y**	**N**	
Musculoskeletal (arthritis, disc disease, ect.)	**Y**	**N**	

BLADDER SATISFACTION SURVEY

Which symptoms best describe you?

Frequent Urination – Day, Night, or Both	Leaking with Sneezing, Coughing, Exercising
Sudden or Strong Urge to urinate	Leaking with Urge or No Warning (Unable to make it to the bathroom in time)
Unable to Empty the Bladder	Bladder or Pelvic Pain

How long have you had these symptoms? _____

Have you tried medications to help your symptoms? Yes No

If yes, check the medications you have tried:

Detrol® LA	Ditropan XL®	Flomax®	Cardura®	Gelnique®
Oxytrol® Patch	Enablex®	VESIcare®	DDAVP®	Toviaz®
Sanctura®	Elavil®	Elmiron®	Other_____	

Did these medications help your symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Completely Cured***

If you've stopped taking your meds explain why:
Did not Help Side Effects Too Expensive

Describe Side Effects _____

Behavior Modifications Tried_____
(i.e., caffeine intake, lifestyle changes, bladder training, pelvic floor muscle training)

What is your level of frustration with your bladder symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated **Very Frustrated**

Do you currently have any problems with bowel function?:
Fecal Incontinence Constipation Other

I am interested in learning more about treatment alternatives to medications:
Yes No

BOWEL CONTROL SATISFACTION SURVEY

Which symptoms best describe you?

- Bowel accidents because I am unable to make it to the bathroom in time
- Bowel accidents while asleep/unaware
- Frequent loose/watery stool
- Abdominal pain

How long have you had these symptoms? _____

Approximately how many bowel accidents do you have per week? _____

Behavior modifications tried _____
(i.e. lifestyle changes, fiber, diet changes, pelvic floor muscle training/biofeedback)

Have you tried medications to help you symptoms? Yes No
If yes, please specify:

Imodium	Lomotil
Imotil	Diphenoxylate
Loperamide	Other _____

Did these medications help your symptoms? Circle #
0 1 2 3 4 5 6 7 8 9 10
No Relief *Completely Cured*

If you've stopped taking your meds, explain why:

Any side effects? _____

What is your level of frustration with your bowel control symptoms? Circle #
0 1 2 3 4 5 6 7 8 9 10
Not Frustrated *Very Frustrated*

I am interested in learning more about other treatment options: Yes No